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Assisted Suicide and Euthanasia: Beyond Terminal Illness

Advocates for physician-assisted suicide and euthanasia often claim these practices will only affect a narrow class of terminally ill patients who are expected to die soon in any case. But there is ample evidence of a "slippery slope" toward ending the lives of patients with chronic illnesses or disabilities, or even those who are vulnerable or marginalized in other ways.

Swiss Group Will Euthanize Those Who 'Feel Old'

"In Switzerland, the association Exit (which has 70,000 members and is one of the biggest euthanasia organisations in the world) has voted to include 'suicide because of old age' on its statute…. Swiss law allows organisations that provide euthanasia services to establish their own internal rules, which may vary from clinic to clinic. The decision of Exit's board has been criticised by the Swiss medical association, which fears that such a move could encourage suicide among the elderly."

> I. Abbadessa ,"Euthanasia Group Votes to Extend Suicide Choice to Those Who 'Feel Old'," *West*, June 2, 2014, http://www.west-info.eu/euthanasia-group-votes-to-extend-suicide-choice-to-those-who-feel-old/

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Euthanasia for Psychiatric Patients in Belgium – Canada Next?

Belgium legalized euthanasia and assisted suicide in 2002 for "unbearable or untreatable suffering," and this is interpreted to cover suffering from psychological conditions. Among the patients receiving lethal drugs are those with depression, personality disorders, and Asperger's syndrome. Says one commentary: "Opponents of the law argued during its deliberation that the primary purpose of psychiatric care should be the prevention of suicide, but the opposing argument that the suffering of psychiatric patients is as 'unbearable' as the suffering of patients with other medical conditions prevailed." Now that Canada's highest court has defined a "right" to euthanasia, supporters are pressing for the same expansion there.

> N. Melville, "Assisted Suicide for Mental Illness Gaining Ground," *Medscape Medical News*, July 31, 2015, http://www.medscape.com/viewarticle/848910; W. Smith, "Canada Push To Allow Mentally Ill Euthanasia," *National Review Online*, April 18, 2017, http://www.nationalreview.com/corner/446838/canada-push-allow-mentally-ill-euthanasia.

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The Dutch Slippery Slope

Since the 1970s a series of court decisions has established that Dutch doctors need not fear punishment for taking their patients' lives or assisting their suicides if they follow certain

guidelines. The guidelines state, among other things, that the patient must have intolerable pain for which there seems to be no other solution. But Dutch practice has become much broader.

On a landmark court ruling in 1986: "The patient in this case was not terminal, nor was she in acute physical pain. The court ruled, nevertheless, that 'psychic suffering' or the 'potential disfigurement of personality' could be acceptable grounds for requesting euthanasia."

> C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (The Free Press 1991) at 39.

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According to judicial guidance in the 1990s, later formalized at the University Medical Center in Groningen ("Groningen protocol"), physicians may give lethal injections to newborn infants with disabilities (most commonly spina bifida). Of 22 such cases analyzed by Groningen physicians, 59% of the infants had a "long life expectancy" – and this was counted *in favor* of euthanasia, as it meant a longer period of suffering and dependence on medical care.

> E. Verhagen et al., "The Groningen Protocol – Euthanasia in Severely Ill Newborns," 352.10 *New England Journal of Medicine* 959-62 (March 10, 2005) at 960, Table 1.

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A Dutch "End-of-Life Clinic," established by a pro-euthanasia group in 2012, provides euthanasia for patients whose regular physicians deny their request, including cases of "a psychiatric or psychological condition, dementia, or being tired of living."

> M. Snijdewind et al., "A Study of the First Year of the End-of-Life Clinic for Physician-Assisted Dying in the Netherlands," 175.10 *JAMA Internal Medicine* 1633-40 (2015) at 1633, http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2426428.

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Dr. Boudewijn Chabot, who forced the issue of assisted suicide for psychiatric patients in the Netherlands by giving a lethal dose to a physically healthy woman in 1991, now says "the euthanasia practice is running amok" in his country. Chabot, who has been called "the Grand Old Man of Dutch euthanasia," says the legal requirements that a patient have unbearable and irreversible suffering and "no reasonable alternative" to euthanasia have become meaningless, as a patient's claim about them is simply accepted as fact. Euthanasia is also increasingly provided by an "End of Life Clinic" that specializes in euthanasia and provides no alternatives. Chabot notes that in ten years, euthanasia cases have grown from two thousand to six thousand a year; since 2009, euthanasia for patients with dementia has increased from 12 to 141, and for chronic psychiatric patients from 0 to 60, calling into question the remaining requirement for a "voluntary and deliberate request" from the patient.

> M. Cook, "A Dutch euthanasia pioneer surveys the wreckage and despairs," *BioEdge*, 24 June 2017, https://www.bioedge.org/bioethics/a-dutch-euthanasia-pioneer-surveys-the-wreckage-and-despairs/12351; B. Chabot, "Worrisome Culture Shift in the Context of Self-Selected Death," *NRC Handelsblad*, June 16, 2017 (English translation with link to original), https://trudolemmens.wordpress.com/2017/06/19/the-euthanasia-genie-is-out-of-the-bottle-by-boudewijn-chabot-translation/

The Difficulties of a "Terminal" Prognosis

Under Oregon law, a request for physician-assisted suicide is valid only if two physicians state that the patient has a "terminal disease" that is "incurable and irreversible" and "will, within reasonable medical judgment, produce death within six months." Ore. Rev. Stat. § 127.800 (12). Yet the actual time from terminal diagnosis and request for lethal drugs, to the patient's death, has ranged from 14 days to 1,009 days (over two-and-a-half years). Of 143 patients in Oregon who died from the prescribed drugs in 2017, *fourteen* were diagnosed as having less than six months to live *in previous years* and given the lethal prescription. This is true of nineteen patients in 2016, seven in 2015 and eleven in 2014.

Oregon Health Authority, "Oregon Death with Dignity Act, http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/index.aspx.

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Patients predicted to have less than six months to live may survive for years. Of the 90 patients who received lethal prescriptions in Oregon in 2016 but did *not* take the drugs, only 36 died the same year of other causes. In one national study, among 900 patients found eligible for hospice care because they were expected to die in less than six months, 70% lived longer.

> Id. at 5; N. Shapiro, "Terminal Uncertainty," in *Seattle Weekly*, January 14, 2009, www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

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In 2018 a Swedish investigator found that the Oregon Health Authority has always interpreted "terminal" to include conditions that can be reversed or even cured, but will likely lead to death in six months *if not treated*. If treatment is refused by the patient, or withheld by others such as a physician, insurance company or government agency, that makes the treatable condition "terminal" and the lethal drugs can be prescribed. This expands the definition of "terminal" to cover patients who could have lived for decades with treatment.

> F. Stahle, "Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model," January 2018, at https://drive.google.com/file/d/1xOZfLFrvuQcazZfFudEncpzp2b18NrUo/view.

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Says Dr. Leslie Blackhall, section head of palliative care at the University of Virginia Medical School: "Predicting how long someone has to live is very imprecise in most conditions that people die of in the United States, where most people die of cancer, heart disease, lung disease (like emphysema), and dementia." The first three conditions cited by Dr. Blackwell make up 87% of the cases that qualified patients for lethal drugs under the Oregon law in 2016.

> See: F. Lowry, "Do Patients Need to Know They Are Terminally Ill?", *Medscape Medical News*, May 2, 2013, http://www.medscape.com/viewarticle/803535; Oregon Public Health Division, op. cit. at 9.

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From the authors of the United States' most extensive study of prognosis and treatment in terminal illness: "Deciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide."

> J. Lynn et al., "Defining the 'Terminally Ill': Insights from SUPPORT," 35.1 *Duquesne Law Review* 311-336 (Fall 1996) at 334.

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Broadening the Agenda to Chronic Illness and Disability in the United States

The *New York Times* reports on former Washington governor Booth Gardner, Parkinson's disease patient and head of that state's successful campaign to legalize physician-assisted suicide:

"Yet the proposed law in Washington wouldn't go far enough for Gardner. It wouldn't include him. Parkinson's isn't terminal… Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide. …. Gardner's campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation's resistance will subside, the culture will shift and laws with more latitude will be passed…"

> D. Bergner, "Death in the Family," *The New York Times Magazine*, December 2, 2007, pp. 38-45, 60, 76, 78, 80, and 82, at 40.

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Some assisted suicide bills in the U.S. are dropping the reference to patients expected to die in six months. In 2017, a New Mexico bill defined "terminal illness" as "a disease or condition that is incurable and irreversible and that in accordance with reasonable medical judgment will result in death within a reasonably foreseeable period of time." No time period is cited.

> W. Smith, "NM Assisted Suicide Bill Moves Toward Death on Demand," *National Review Online*, Feb. 12, 2017, http://www.nationalreview.com/corner/444835/nm-assisted-suicide-bill-moves-toward-death-demand.

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Filing suit in Montana to urge recognition of a state constitutional right to physician-assisted suicide for "terminally ill adult patients," the organization Compassion & Choices told the court this includes patients with chronic conditions who could live a long time if they receive treatment: "The term 'terminally ill adult patient,' as used in the complaint, means a person 18 years of age or older who has an incurable *or* irreversible condition that, *without the administration of life-sustaining treatment*, will, in the opinion of his or her attending physician,

result in death within a relatively short time. This definition is not limited to any specific set of illnesses, conditions or diseases."

> Plaintiffs' Responses to State of Montana's First Discovery Requests, Answer No. 4, *Baxter v. Montana*, No 2007-787 (Mont. 1st Dist., May 16, 2008) (emphasis added).

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In 2009, assisted suicide advocates proposed a bill in New Hampshire (HB 304) allowing doctors to prescribe a lethal dose for patients with a "terminal condition." The bill defined "terminal condition" as "an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death" (Sec. 137-L:2 (XIII)). Commented disability rights advocate Stephen Drake: "[T]erminality is defined as having a condition that is irreversible and will result in a premature death. Many people I work with… fit the definition. None of them are dying."

> S. Drake, "New Hampshire Poised to Redefine 'Terminally Ill' - to PWDs and others for Assisted Suicide Eligibility," *Not Dead Yet* News Commentary, Jan. 30, 2009, http://notdeadyetnewscommentary.blogspot.com/2009/01/new-hampshire-poised-to-redefine.html.

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On the people "assisted" by Jack Kevorkian, who took part in an estimated 130 deaths: "The first reported patient to seek him out and receive his aid was a 54-year-old woman with Alzheimer's disease. His first eight such patients were women, and half of them had no terminal condition. Of the reported 75 suicides Kevorkian assisted through 1997, according to research by Silvia Canetto, a psychology professor specializing in the study of suicide at Colorado State University, 72 percent were women, and more than three-quarters of those women were not terminally ill. (Multiple sclerosis affected about 30 percent of them.)"

> D. Bergner, op. cit., at 41. Also see L. Roscoe et al., "Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998," 343.23 *New England Journal of Medicine*1735-6 (December 7, 2000) (reporting that "only 25 percent" of Kevorkian's clients were terminally ill).

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Hemlock Society founder Derek Humphry on seniors in nursing homes: "Surveys have consistently found that most people would rather continue living at home rather than in a nursing home. What has not been known until recently, however, is that the aversion to 'such a facility is so strong that 30% of those surveyed said they would rather *die* than live permanently in a nursing home.' This information begs the question: Why do we, as a nation, not allow these people to die, if they have no alternative to a nursing home existence and this is what they want? Their lives would conclude with dignity and self-respect, and one measure of cost containment would be in place."

> D. Humphry and M. Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (St. Martin's Press 1998) at 319 (emphasis in original).

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Collateral Damage? Assisted Suicide's Impact on Suicides Generally

Publicity about suicide and assisted suicide, especially when it presents these favorably, leads to more suicides. This is the "collateral damage" of the assisted suicide agenda.

The World Health Organization warns that certain kinds of media coverage of suicide can lead to "imitative suicidal behaviours," especially among young or depressed people. The WHO warns: "Avoid language which sensationalizes or normalizes suicide, or presents it as a solution to problems"; "Avoid explicit description of the method used in a completed or attempted suicide."

> World Health Organization, *Preventing Suicide: A Resource for Media Professionals* (WHO: Geneva 2008) at 6, 7, 8; www.who.int/mental_health/prevention/suicide/resource_media.pdf.

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Unfortunately, proponents of assisted suicide engage in exactly this kind of publicity. In the year after the Hemlock Society published Derek Humphry's book *Final Exit*, recommending a particular method for "rational suicide" in cases of terminal illness, the number of suicides by this method in New York City increased by a factor of four (from 8 to 33). During that period there was direct evidence that "at least 15 of the 144 people who committed suicide by asphyxiation or poisoning had probably been exposed to the book…. We found that most persons exposed to *Final Exit* were not terminally ill and had used it as a suicide manual."

> P. Marzuk et al., "Increase in Suicide by Asphyxiation in New York City After the Publication of *Final Exit*," 329.20 *New England Journal of Medicine* 1508-10 (Nov. 11, 1993) at 1509, 1510. Also see P. Chappell et al., "Final Exit and the Risk of Suicide," 267.22 *Journal of the American Medical Association* 3027 (June 10, 1992).

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Oregon's law allowing physician-assisted suicide took effect in late 1997. In 2015 the state's health department said "The rate of suicide among Oregonians has been increasing since 2000" and as of 2012 was "42% higher than the national average"; suicide had become "the second leading cause of death among Oregonians aged 15 to 34 years." This trend continued in 2014, when the state's suicide rate was 43.1% higher than the national average. These figures are in addition to deaths under the Oregon assisted suicide law, which legally are not counted as suicides.

> X. Shen and L. Millet, *Suicides in Oregon: Trends and Associated Factors. 2003-2012* (Oregon Health Authority 2015) at 3, http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202015%20report.pdf; Oregon Health Authority, *Oregon Vital Statistics Annual Report 2015* (Dec. 2016), Vol. 2 at 6-26, https://digital.osl.state.or.us/islandora/object/osl%3A94197.

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Proponents claim physician-assisted suicide is a "peaceful" alternative that replaces "violent" suicides. A recent study has found that this is not the case: Legalizing assisted suicide does not reduce or substitute for other suicides, but increases total suicides.

D. Jones and D. Paton, “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?”, 108 *Southern Medical Journal* (2015): 599-604.

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